WASHINGTON STATE DEPARTMENT OF HEALTH
FAMILY PLANNING AND REPRODUCTIVE HEALTH
CHART REVIEW WORKSHEET

Agency Name:	Completed by:	Date:

☐ = Heavy lines indicate required ☐ = Normal lines indicate should or as indicated X = Information present and reasonably complete O = No Information recorded NA = Not Applicable SC = See Comments **Client ID #**	**Initial Visit**					**Revisit**					**Pregnancy Test Visit**			**STD/HIV Visit**			**Other Medical**	
A. IDENTIFYING INFORMATION																		
1. Name and address																		
2. Date of birth																		
3. How to contact																		
4. Gross monthly income, family size, and discount fee category																		
B. INITIAL COMPREHENSIVE HISTORY FOR ALL CLIENTS (Check on revisits as indicated)																		
1. Illness, hospitalizations, surgery, blood transfusion, chronic or acute conditions																		
2. Allergies																		
3. Medications: current prescription & OTC																		
4. Tobacco extent of use																		
5. Drugs extent of use																		
6. Alcohol extent of use																		
7. Immunization: Rubella & Hepatitis B																		
8. Review of systems																		
9. Family health and social history																		
10. Partner history: IVDU, multiple partners, bisexual, risk for STD/HIV																		
11. Sexual history																		
12. STD and HIV																		

Agency Name:	Completed by:	Date:

☐ = Heavy lines indicate required ☐ = Normal lines indicate should or as indicated X = Information present and reasonably complete O = No Information recorded NA = Not Applicable SC = See Comments **Client ID #**	**Initial Visit**					**Revisit**					**Pregnancy Test Visit**			**STD/HIV Visit**			**Other Medical**	
C. INITIAL COMPREHENSIVE HISTORY FOR FEMALE CLIENTS																		
1. Contraceptive use past and current and adverse effects																		
2. Pap smear history: last pap, any abnormal, treatment																		
3. Gynecological history																		
4. Obstetrical history																		
5. DES exposure in utero (1940-1970)																		
D. PHYSICAL ASSESSMENT & TREATMENT																		
1. Height																		
2. Weight																		
3. Blood pressure																		
4. Thyroid																		
5. Heart																		
6. Lungs																		
7. Breast																		
a. Self-exam instructions/SBE																		
8. Abdomen																		
9. Extremities																		
10. Rectum																		
11. Colo-rectal screening >40 yrs																		
12. a. Pelvic exam, including bimanual exam																		
b. Exam of penis, testes, prostate																		
c. Self testicles exam/STE																		

Agency Name:	Completed by:	Date:

☐ = Heavy lines indicate required ☐ = Normal lines indicate should or as indicated X = Information present and reasonably complete O = No Information recorded NA = Not Applicable SC = See Comments **Client ID #**	**Initial Visit**					**Revisit**					**Pregnancy Test Visit**			**STD/HIV Visit**			**Other Medical**	
13. STD and HIV screening, as indicated																		
14. Deferred exam less than 3mos (S), 6mos (M)																		
15. Preventive service(s) declined/deferred are documented in record.																		
16. Medical services(s) declined/deferred are documented in record.																		
17. Clinical impression or diagnosis.																		
18. Prescription or medication dispensed.																		
19. Treatment provided																		
a. Treatment referral made																		
b. Treatment report back from provider																		
c. Treatment followed up with client																		
F. LABORATORY (*Required for certain contraceptive methods)																		
1. Hb &/or Het *																		
2. Pap Smear																		
3. Pregnancy test (PRN)																		
4. G.C. culture (IUD's & when indicated)																		
5. Chlamydia screening (high risk criteria used)																		
6. RPR/syphilis serology *																		
7. Wet mount *																		
8. Hepatitis B (Hbsag, Hbsab)																		
9. HIV Test *																		
10. Urinalysis *																		
11. Rubella titer *																		
12. Cholesterol and Lipids *																		

Agency Name:	Completed by:	Date:

☐ = Heavy lines indicate required ☐ = Normal lines indicate should or as indicated X = Information present and reasonably complete O = No Information recorded NA = Not Applicable SC = See Comments **Client ID #**	**Initial Visit**					**Revisit**					**Pregnancy Test Visit**			**STD/HIV Visit**			**Other Medical**	
13. Diabetes *																		
14. Client notified of abnormal results																		
F. CLIENT EDUCATION AND COUNSELING																		
1. Client education documented.																		
2. Informed consent for general clinic services																		
3. Informed consent for specific contraceptive method																		
4. Confidentiality assurance statement																		
5. Method counseling documented in record.																		
6. STD and HIV risk reduction counseling documented in record.																		
7. Counseling provided on risks of deferring or declining services.																		
8. Return to clinic schedule																		
9. Clients with positive pregnancy test offered information on all options.																		
10. Pregnant clients carrying to term provided information on nutrition, and risk of smoking, drugs, alcohol, and x-rays.																		
11. Pregnant clients carrying to term referred to prenatal care.																		
12. Clients with suspected ectopic pregnancy given referral for dx and tx.																		
13. Clients with negative pregnancy test given information on contraception or infertility.																		
G. CHARTING BY CLINICIAN																		
1. All entries signed & all lab slips initialed																		

Agency Name:	Completed by:	Date:

☐ = Heavy lines indicate required ☐ = Normal lines indicate should or as indicated X = Information present and reasonably complete O = No Information recorded NA = Not Applicable SC = See Comments **Client ID #**	**Initial Visit**					**Revisit**					**Pregnancy Test Visit**			**STD/HIV Visit**			**Other Medical**	
2. All entries dated																		
3. Entries in ink																		
4. Handwriting is legible																		
5. Consistent abbreviations used																		
6. Charting is concise, objective, & clear																		
H. CHART STRUCTURE																		
1. Client ID on each page																		
2. Allergies noted in prominent location																		
3. Contents in chronological order																		
4. Sections separated by tabs																		
5. Contents securely anchored																		
6. History format is easy to read																		
7. Physical assessment format is easy to read																		
8. No unnecessary duplication on forms																		

I. COMMENTS and SUGGESTIONS (If necessary, use back side of this page.)

J. RECOMMENDATIONS FOR CORRECTIVE ACTION: